North Carolina Quality Assessment and Improvement Strategies
Initial Strategy
July 17, 2003

I. Process for Quality strategy development, review and revision

A. In developing the quality assessment and improvement strategies, North Carolina has amended the HMO contract to include BBA-compliant requirements. The amendments include the following:

- The Plan must have an overall quality improvement program that is integrated into the plan's activities and involves key decision-making staff
- The Plan must submit regular reporting to ensure access to quality health care to include:
  - A patient (CAHPS) and a provider satisfaction survey annually
  - Requested HEDIS data and DMA measures re: utilization and plan performance.
  - Complaint and grievance reports quarterly
  - Requested data for CSHCNs
- The Plan must develop and implement a minimum of two performance improvement projects that focus on clinical and non-clinical areas the first year, three projects in year two and four projects in year three of the contract.

The State plans to amend the current Medical Review of North Carolina, Inc. contract to include the external quality review (EQR) requirements as outlined in the BBA. This contract will end during the fourth quarter of calendar year 2004 at which time we will issue a request for proposal for EQRO contracting effective January 1, 2005.

B. Once this initial strategy is approved by CMS, the State plans to hold a public meeting at the Mecklenburg County Department of Social Services in Charlotte, North Carolina for stakeholders and beneficiary input into this strategy. We plan to hold this meeting during the fourth quarter of calendar year 2003. In addition, the State will post the initial strategy on the DMA web page and instruct all interested parties to address their comments to Managed Care staff.

C. The State plans to conduct an annual review of the effectiveness of this strategy during the fourth quarter of each calendar year following receipt and review of the EQRO report and the annual Plan reporting.

D. The State considers a change to be significant enough for stakeholder review when the numbers, types, or timeframes of reporting are revised. Medicaid agency staff will analyze the yearly Statistical reporting data submitted by the MCO, as outlined in Appendix V of the MCO contract, and the complaints filed with the State's Quality Management staff to determine when a change is significant enough for a stakeholder review.

E. The State plans to update the strategy during the fourth quarter of each calendar year when the effectiveness of the strategy is reviewed.

II. Managed Care Program Goals and Objectives

The goals and objectives of the State's managed care program are:

- To promote acceptable standards of health care within managed care programs by monitoring internal/external processing for improvement opportunities and assisting the Plan with the implementation of strategies for improvement
- To ensure quality of care through contract compliance within all managed care programs
- To promote the appropriate utilization of services within acceptable standards of medical practice
- To coordinate quality management activities within Managed Care as well as with external customers
- To comply with State and Federal regulatory requirements through the development and monitoring of QM policies and procedures

The priority of the State's plan is to ensure access to quality care for HMO enrollees and will utilize strategic partnerships between the HMO, the DSS, the enrollment broker and the beneficiary to improve access, quality and continuity of care. The State fosters the strategic partnerships through regular HMO Quality Management and Plan mobilization meetings. The stakeholder meetings to discuss the initial strategy will also foster partnerships for quality improvement.

III. Medicaid contract provisions

A. Access to Care

Access to care is stated in the MCO contract as follows:

6.3 Emergency Medical Services

In accordance with 1932(b)(2) of the Social Security Act as amended by the Balanced Budget Act (BBA) of 1997, the Plan shall provide coverage for emergency services consistent with the prudent layperson standard, as defined in Appendix I. Such services shall be provided at anytime without regard to prior authorization and without regard to the emergency care provider's contractual relationship with the Plan. The Plan shall also comply with guidelines relating to promoting efficient and timely coordination of

appropriate maintenance and post-stabilization care provided to a Medicaid enrollee who is determined to be stable by a medical screening examination, as required under the Examination and Treatment for Emergency Medical Conditions and Women in Labor Act – EMTALA. (Section 1867 of the Social Security Act). (See Appendix XVI). The Plan is responsible for educating Members on the availability, location**,** and appropriate use of emergency services. The Plan may not deny payment for treatment obtained when an enrollee had an emergency medical condition, including but not limited to, cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 C.F.R. 438.114(a) of the definition of emergency medical condition. The Plan shall not deny payment or treatment obtained when a representative of the Plan instructs the enrollee to seek emergency services.

6.4 Accessibility of Services

The Plan must establish and maintain appropriate provider networks that are sufficient to provide adequate access to all services covered under the contract for the enrolled Medicaid population, including children with special health care needs. These provider networks shall offer an appropriate range of services and access to primary care, preventive services, and specialty services. This network of appropriate providers must be supported by written agreements. The network must have a sufficient number, mix, and geographic distribution of providers of services to assure the Division that medically necessary Covered Services for the Plan's Members are delivered in a timely and appropriate manner according to the Division's Access Standards (Appendix XV). If particular specialty physician services are medically necessary but are not accessible within the Plan's network, the Plan must arrange for these services to be provided to its enrollees. The Plan must adequately and timely cover these services out of network for the enrollee for as long as the Plan is unable to provide them in network. The Plan shall ensure that all Covered In-Plan Services are as accessible to Members (in terms of timeliness, amount, duration, and scope) as those services are to non-enrolled Medicaid Recipients within the area and that no incentive is provided to providers, monetary or otherwise, for withholding medically necessary services. The Plan shall provide for a second opinion from a qualified health care professional within the network, or arrange for the ability of the enroll to obtain one outside the network, at no cost to the enrollee.

The Plan shall provide female enrollees with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventative care services. This is in addition to the enrollee's designated source of primary care if that source is not a woman's health specialist.

Plans shall be required to cooperate with the City of Charlotte to develop the infrastructure necessary to serve those geographic locations most heavily populated by Medicaid Members. The Plan must provide the Division at least thirty (30) days notice prior to the proposed effective date if it plans to change a location, services, or reduce availability. The Plan must notify in writing those Members affected by such a change at least fifteen (15) business days prior to the effective date of such changes, or as soon as possible in the cases of unforeseen circumstances. The Plan must make a good faith effort to give written notice of termination of a contracted provider, within fifteen (15) days after receipt or issuance of the termination notice, to each enrollee who received his or her primary care from, or was seen on a regular basis by, the terminated provider.

The Plan must provide toll-free telephone medical advice by a licensed medical professional, either directly or through its network providers, to Members twenty-four (24) hours per day, seven (7) days per week. The Plan shall maintain a record of encounters on the telephone medical advice line, including the date of call, type of call, and resolution. The Plan is responsible for educating Members on medical advice procedures.

The Division shall have the right to review periodically the adequacy of service locations, the hours of operation, and the availability and appropriateness of telephone medical advice. The Division may require the Plan to take corrective action to improve member access to services based on periodic reviews.

6.5 Appointment Availability

The Plan must ensure that appropriate services are available as follows:

a. Emergency - immediately upon presentation or notification;
b. Urgent care - within twenty-four (24) hours;
c. Routine sick care - within three (3) days;
d. Well/Preventive care - within ninety (90) days except in the case of a woman who is pregnant, then within fifteen (15) business days;
e. Routine Plan Specialty care - within ninety (90) days;
f. Telephone medical advice – twenty four (24) hours a day and return call to Member within one (1) hour;
g. New Member Health Assessment Encounter - within ninety (90) days of enrollment; except in the case of a woman who is pregnant, then within fifteen (15) business days of enrollment;
h. Child in DSS custody - within seven (7) days; immediately when child is under age two (2) or DSS staff determines the child has chronic or emergent medical need(s).

6.6 Appointment Wait Time

The Plan must agree to provide services within the following wait times:

a. Scheduled appointment - within one (1) hour;
b. Walk-in - within two (2) hours or schedule for subsequent appointment;
c. Life-threatening emergencies - must be managed immediately.

6.8 Choice of Health Professional

The Plan must have written policies and procedures for assigning each of its Medicaid Members to a Primary Care Provider appropriate to each member's needs. To the extent practical, the Plan must offer freedom of choice to Members in selecting or changing to a different PCP within the Plan, in accordance with its policies for other enrolled groups. However, for an enrollee of a single MCO under paragraph (b)(2) or (b)(3) of section 438.52, any limitation the Division imposes on his or her freedom to change between primary care providers may be no more restrictive than the limitation on disenrollment under 438.56(c). The Plan must agree to assign no more than two thousand (2,000) Members to any one full-time-equivalent provider in its network without the written approval of the Division. The Division encourages the Plan to include among its available providers any county, State, or Federally qualified provider that currently serves Recipients in the service area, including Federally Qualified Health Centers (FQHCs), in-plan school-based health services, and county health departments.

The Plan shall allow children with special needs who utilize Specialists frequently for their health care to maintain these types of Specialists as PCPs, or be allowed direct access to these Specialists for the needed care. A Member who has received prior authorization from the Plan for referral to a Specialist or for inpatient care shall be allowed to choose from among all the available Specialists and hospitals within the Plan, to the extent reasonable and appropriate.

The Plan shall implement procedures to ensure that each enrollee has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the enrollee. The Plan shall implement procedures to coordinate services it furnishes to the enrollee/member with services the enrollee/member receives from any other MCO,

Prepaid Inpatient Health Plan (PIHP) or Prepaid Ambulatory Health Plan (PAHP). The Plan shall implement procedures to share with other MCOs, PIHPs or PAHPs serving the enrollee/member so that those activities need not be duplicated. The Plan shall implement procedures to share the results of its identification and assessment of the enrollee/member with special health care needs, as defined by the Division, so that these activities need not be duplicated.

B. Structure and Operations

The following sections of the MCO contract addresses Structure and Operations:

6.7 Member Services

The Plan must staff a Member Services Department to be responsible for:

a. Explaining the operation of the Plan and answering Member questions;
b. Assisting Members in making appointments and in obtaining appropriate services;
c. Assisting Members in securing medically necessary, non-ambulance transportation;
d. Handling Member complaints and providing information on grievance and appeal procedures;
e. Assisting the HBM with providing appropriate Plan information;
f. Resolving claim disputes and processing appeals;
g. Operating a toll free Member Services telephone line to provide information and education during normal business hours.

6.10 Facilities and Resources

The Plan must provide directly or by contract the following:

a. Specialists for adult and pediatric care, including care appropriate to children with special health care needs, the elderly, disabled, and adolescent enrollees;
b. Experienced and qualified case management staff;
c. One fully accredited general acute care hospital bed per seven hundred twenty seven (727) enrollees;
d. A designated emergency service facility providing care twenty four (24) hours a day, seven (7) days a week;
e. Facilities at all service locations, which meet the applicable Federal, State, and local requirements, pertaining to health care facilities and laboratories; all laboratory-testing sites providing services under the Contract must have either a Clinical Laboratory (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number;
f. Telecommunications system sufficient to meet the needs of the Members;
g. A qualified in-state Plan Administrator;
h. Sufficient support staff;
i. A licensed physician to serve as Medical Director to oversee and be responsible for the proper provision of covered Services to Members;
j. A qualified Quality Assurance director;
k. A data processing person qualified to provide necessary and timely reports and encounter data to the Division.

6.11 Orientation of New Members

The Plan shall provide each new Member, within fourteen (14) days from enrollment, written information on the Plan. All new Member Plan material must be approved by the Division prior to its release, and shall include at least the following information:

a. A list of PCPs, the procedures for selecting an individual physician and scheduling an initial health assessment encounter within the timeframes established in Sections 6.14 and 6.15 of this contract;
b. Procedures for changing PCPs or other practitioners;
c. Information specified in 42 C.F.R. 438.10(f)(6) and 42 C.F.R. 438.10(g);
d. Benefits and services provided and any limitations or exclusions applicable to In-Plan Services;
e. Procedures for notifying Members affected by the termination or change in any benefits, services, service delivery, or office site;
f. Member rights and responsibilities**,** including the right to voluntarily change or disenroll from a health plan, procedures for disenrollment and the right to change PCPs within the Plan;
g. Referral policy for specialty care and a current list of specialty care providers;
h. Provisions for after-hour and emergency care;
i. Role of primary care providers (PCPs);
j. How to access services;
k. The right to formulate Advance Directives;
l. Procedures for obtaining out of area coverage or services;
m. The right to receive family planning services and supplies from Out-of-Plan Providers;
n. Policies regarding the treatment of minors;
o. Any limitations that may apply to services obtained from Out-of-Plan Providers, including a disclosure of the responsibility of Members to pay for unauthorized health care services obtained from Out-of-Plan Providers, and the procedures for obtaining authorization for such services;
p. Circumstances under which a Member may transfer or be involuntarily disenrolled from the Plan;
q. Rights, procedures and timeframes for voicing or filing complaints and grievances or recommending changes in policies and services;
r. Rights, procedures and timeframes for appealing adverse determinations affecting coverage, benefits or enrollment, including the right to appeal directly to the Division;
s. Process for accessing the Health Benefits Manager;
t. Information about the Plan's ability to make reasonable accommodations for people with disabilities;
u. Information concerning transportation arrangements offered by the Plan;
v. Charges to Members.

6.12 Notice to Current Enrollees and Potential Enrollees

The Plan shall have in place a mechanism to help enrollees and potential enrollees understand the requirements and benefits of the Plan. The Plan shall have written policies regarding the enrollee rights specified in 42 C.F.R. 438.100. The Plan must provide information to current enrollees and potential enrollees in their service area concerning:

a. Enrollee rights and responsibilities as set forth in 42 C.F.R. 438.100 and sections referenced therein;
b. The identity, locations, qualifications and availability of health care providers that participate in the Plan;
c. Grievance and appeal procedures;
d. Information on covered items and services;
e. Written information must be made available in the prevalent non-English languages in a particular service area;
f. Availability of oral interpretation service for any language and how to access the service;

g. Availability of interpretation of written information in prevalent languages and how to access those services;
h. Written material must use an easily understood language and format; and be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency. All enrollees and potential enrollees must be informed that information is available in alternative formats and how to access those formats.

All materials must pass current North Carolina readability requirements, G.S. 58-38-1 et. seq. and G.S. 58-67-65 (a)(3).

The Plan must give each enrollee written notice of any " significant" change in the information specified in 42 C.F.R. 438.10(f)(6) and 42 C.F.R. 438.10(g) at least thirty (30) days before the intended effective date of the change. The Division defines significant as changes that require modifications to the State Plan.

C. Quality Measurement and Improvement

The MCO contract provisions related to Quality measurement and Improvements are:

7.1 <u>Internal Quality Assurance/Performance Improvement Program</u>

The Plan shall establish and maintain a written program for Quality Assurance/Performance Improvement ("QA/PI") consistent with 42 C.F.R. 434.34 and 42 C.F.R. 438.240 and with the utilization control program required by CMS for the Division's overall Medicaid program as described in 42 C.F.R. 456.

The Plan shall submit the written Quality Assurance/Performance Improvement program description and a summary of progress toward performance improvement goals to the Division on an annual basis no later than June 30th of each calendar year.

The written program must describe, at a minimum, how the Plan shall:

- Achieve CMS and/or Division or Plan defined minimum performance levels on standardized quality measures annually. (See Appendix XVIII for Benchmark Performance Levels);
- Develop and implement performance improvement projects using data from multiple sources that focus on clinical and non-clinical areas. These projects must achieve, through ongoing measurements and intervention, demonstrable and sustained improvement in significant aspects of care that can be expected to have a favorable effect on health outcomes and enrollee satisfaction;
- Have in effect mechanisms to detect both over and under utilization of services;
- Have in effect mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs;
- Have a comprehensive scope that assures all demographic groups, care settings, and types of services are included in the scope of the review occurring over multiple review periods;
- Measure the performance of Plan providers and conduct peer review activities such as: identification of practices that do not meet Plan standards; recommendation of appropriate action to correct deficiencies; and monitoring of corrective action by providers;
- Measure provider performance through inclusion of medical record audits;
- Provide performance feedback to providers, including detailed discussion of clinical standards and expectations of the Plan;

- Develop and/or adopt clinically appropriate practice parameters and protocols/guidelines and provide the Plan's providers enough information about the protocols/guidelines to enable them to meet the established standards;
- Evaluate access to care for Enrollees according to established standards and those developed by the Plan and implement a process for ensuring that network providers meet and maintain the standards. The evaluation should include an analysis of the accessibility of services to Enrollees with disabilities.

1. The Plan shall develop, implement, and report to the Division a minimum of two (2) plan-specific and self-funded performance improvement projects the first year of this contract: one focusing on a clinical area and one focusing on a non-clinical area. The topics for these projects shall be jointly determined by the Plan and the Division based on statistical reports submitted to the Division the previous year**.** Progress summaries of these projects shall be submitted to the Division by June 30 of each calendar year. (See Appendix V and XVI). For year two of this contract, the Plan shall conduct a performance improvement project in addition to the two planned for the first year of this contract for a total of three. For year three of the contract, the Plan shall conduct an additional performance improvement project for a total of four. The project topics shall be jointly determined by the Plan and the Division unless mandated by CMS and based on Plan performance as measured by annual reporting to the Division;
2. The plan, at its own expense, shall participate annually in at least one (1) statewide performance improvement project. (See Appendix V);
3. The Plan shall conduct an annual Consumer Assessment of Health Plan Survey (CAHPS), utilizing the sampling and format as defined by NCQA. The results of the survey must be filed with the Division as stated in Appendix V, Statistical Reporting Requirements;
4. The Plan shall maintain an active QA/PI committee or other structure, which shall be responsible for carrying out the planned activities of the Quality Assessment/Performance Improvement program. This committee shall have regular meetings, shall document attendance by providers, and shall be accountable and report regularly to the governing board or its designee concerning QA/PI activities. The Plan shall maintain records documenting the committee's findings, recommendations, and actions;
5. The Plan shall designate a senior executive who shall be responsible for program implementation. The Plan's Medical Director shall have substantial involvement in the QA/PI program functions, such as credentialing and utilization review and review and monitoring of its subcontractors.

IV. State Standards for Access to Care

A.1. Availability of Services: In the HMO contract under section 6.4, the Plan is required "to establish and maintain appropriate provider networks that are sufficient to provide adequate access to all services covered under the contract for the enrolled Medicaid population, including children with special health care needs. These provider networks shall offer an appropriate range of services and access to primary care, preventive services, and specialty services. This network of appropriate providers must be supported by written agreements. The network must have a sufficient number, mix, and geographic distribution of providers of services to assure the Division that medically necessary Covered Services for the Plan's Members are delivered in a timely and appropriate manner according to the Division's Access Standards (Appendix XV). If particular specialty

physician services are medically necessary but are not accessible within the Plan's network, the Plan must arrange for these services to be provided to its enrollees. The Plan must adequately and timely cover these services out of network for the enrollee for as long as the Plan is unable to provide them in network. The Plan shall ensure that all Covered In-Plan Services are as accessible to Members (in terms of timeliness, amount, duration, and scope) as those services are to non-enrolled Medicaid Recipients within the area and that no incentive is provided to providers, monetary or otherwise, for withholding medically necessary services. The Plan shall provide for a second opinion from a qualified health care professional within the network, or arrange for the ability of the enroll to obtain one outside the network, at no cost to the enrollee.

The Plan shall provide female enrollees with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive care services. This is in addition to the enrollee's designated source of primary care if that source is not a woman's health specialist."

Section 7.6 of the HMO contract states "The Plan shall have written policies and procedures for provider credentialing and recredentialing to identify providers who fall under its scope of authority and action and shall adhere to such polices and procedures. The Plan shall demonstrate that its providers are credentialed by providing the Division a copy of their policies and procedures. The Division shall review the Plan's provider credentialing and recredentialing process during the annual independent external review. The policies and procedures established by the Plan to verify and document provider credentials shall comply with all applicable State and Federal credentialing and recredentialing polices, requirements and regulations, including but not limited to, credentialing and recredentialing requirements as determined by the North Carolina Department of Insurance."

Regarding timely access, the MCO contract states in 6.5 and 6.6 the following,

"The Plan must ensure that appropriate services are available as follows:

a. Emergency - immediately upon presentation or notification;
b. Urgent care - within twenty-four (24) hours;
c. Routine sick care - within three (3) days;
d. Well/Preventive care - within ninety (90) days except in the case of woman who is pregnant, then within fifteen (15) business days;
e. Routine Plan Specialty care - within ninety (90) days;
f. Telephone medical advice – twenty four (24) hours a day and return call to Member within one (1) hour;

g. New Member Health Assessment Encounter - within ninety (90) days of enrollment; except in the case of a woman who is pregnant, then within fifteen (15) business days of enrollment;
h. Child in DSS custody - within seven (7) days; immediately when child is under age two (2) or DSS staff determines the child has chronic or emergent medical need(s).

The Plan must agree to provide services within the following wait times:

a. Scheduled appointment - within one (1) hour;
b. Walk-in - within two (2) hours or schedule for subsequent appointment;
c. Life-threatening emergencies - must be managed immediately.

The Plan must staff a Member Services Department to be responsible for:

a. Explaining the operation of the Plan and answering Member questions;
b. Assisting Members in making appointments and in obtaining appropriate services;
c. Assisting Members in securing medically necessary, non-ambulance transportation;
d. Handling Member complaints and providing information on grievance and appeal procedures;
e. Assisting the HBM with providing appropriate Plan information;
f. Resolving claim disputes and processing appeals;
g. Operating a toll free Member Services telephone line to provide information and education during normal business hours."

Regarding cultural sensitivity, section 6.19 of the HMO contract states, "The Plan shall develop strategies for addressing the special needs of the Medicaid population. Strategies should incorporate the use of staff training to increase awareness and sensitivity to the needs of persons who may be disadvantaged by low income, disability and illiteracy, or who may be non-English speaking. Staff training should include topics such as sensitivity to different cultures and beliefs, the use of bilingual interpreters, the use of Relay NC, TTY machines, and other communication devices for the disabled, overcoming barriers to accessing medical care, understanding the role of substandard housing, poor diet, and lack of telephone or transportation for health care needs."

2. Assurances of Adequate Capacity and Services

Sections 6.2. 6.3 and 6.4 of the MCO contract states the following:

In Section 6.2, Covered Services are addressed by requiring the following of the MCO: **"**The Plan shall provide to Recipients enrolled

under this Contract, directly or through arrangements with others, all of the Covered Services identified in Appendix III and as set forth in this contract. Covered services must be medically necessary and provided by, or under the direction of a physician. The Plan shall provide the same standard of care for all Members regardless of eligibility category, and shall make all services as accessible in terms of timeliness, amount, duration and scope, to Medicaid Members, as those services are to non-enrolled Medicaid Recipients within the same area. The Plan shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness or condition. Organ transplants shall be covered under the same conditions as fee-for-service. Covered services are defined in the respective Medicaid Provider Manuals and Bulletins, which are incorporated by reference. The Plan shall have in effect mechanisms to ensure consistent application of review criteria for authorization decisions; and consult with the requesting provider when appropriate."

Access to Emergency Medical Services is outlined in Section 6.3, which states, "In accordance with 1932(b)(2) of the Social Security Act as amended by the Balanced Budget Act (BBA) of 1997, the Plan shall provide coverage for emergency services consistent with the prudent layperson standard, as defined in Appendix I. Such services shall be provided at anytime without regard to prior authorization and without regard to the emergency care provider's contractual relationship with the Plan. The Plan shall also comply with guidelines relating to promoting efficient and timely coordination of appropriate maintenance and post-stabilization care provided to a Medicaid enrollee who is determined to be stable by a medical screening examination, as required under the Examination and Treatment for Emergency Medical Conditions and Women in Labor Act – EMTALA. (Section 1867 of the Social Security Act). (See Appendix XVI). The Plan is responsible for educating Members on the availability, location**,** and appropriate use of emergency services. The Plan may not deny payment for treatment obtained when an enrollee had an emergency medical condition, including but not limited to, cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 C.F.R. 438.114(a) of the definition of emergency medical condition. The Plan shall not deny payment or treatment obtained when a representative of the Plan instructs the enrollee to seek emergency services.

In regards to accessibility of services, Section 6.4 states: "The Plan must establish and maintain appropriate provider networks that are sufficient to provide adequate access to all services covered under the contract for the enrolled Medicaid population, including children with special health care needs. These provider networks shall offer an appropriate range of services and access to primary care, preventive services, and specialty services. This network of appropriate providers must be supported by written agreements. The network must have a sufficient number, mix, and geographic distribution of providers of services to assure the Division that medically

necessary Covered Services for the Plan's Members are delivered in a timely and appropriate manner according to the Division's Access Standards (Appendix XV). If particular specialty physician services are medically necessary but are not accessible within the Plan's network, the Plan must arrange for these services to be provided to its enrollees. The Plan must adequately and timely cover these services out of network for the enrollee for as long as the Plan is unable to provide them in network. The Plan shall ensure that all Covered In-Plan Services are as accessible to Members (in terms of timeliness, amount, duration, and scope) as those services are to non-enrolled Medicaid Recipients within the area and that no incentive is provided to providers, monetary or otherwise, for withholding medically necessary services. The Plan shall provide for a second opinion from a qualified health care professional within the network, or arrange for the ability of the enroll to obtain one outside the network, at no cost to the enrollee.

The Plan shall provide female enrollees with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventative care services. This is in addition to the enrollee's designated source of primary care if that source is not a woman's health specialist.

Plans shall be required to cooperate with the City of Charlotte to develop the Medicaid Members. The Plan must provide the Division at least thirty (30) days notice prior to the proposed effective date if it plans to change a location, services, or reduce availability. The Plan must notify in writing those Members affected by such a change at least fifteen (15) business days prior to the effective date of such changes, or as soon as possible in the cases of unforeseen circumstances. The Plan must make a good faith effort to give written notice of termination of a contracted provider, within fifteen (15) days after receipt or issuance of the termination notice, to each enrollee who received his or her primary care from, or was seen on a regular basis by, the terminated provider.

The Plan must provide toll-free telephone medical advice by a licensed medical professional, either directly or through its network providers, to Members twenty-four (24) hours per day, seven (7) days per week. The Plan shall maintain a record of encounters on the telephone medical advice line, including the date of call, type of call, and resolution. The Plan is responsible for educating Members on medical advice procedures.

The Division shall have the right to review periodically the adequacy of service locations, the hours of operation, and the availability and appropriateness of telephone medical advice. The Division may require the Plan to take corrective action to improve member access to services based on periodic reviews."

3. Coordination and Continuity

Section 6.8, 6.14 and 6.36 state "The Plan must have written policies and procedures for assigning each of its Medicaid Members to a Primary Care Provider appropriate to each member's needs. To the extent practical, the Plan must offer freedom of choice to Members in selecting or changing to a different PCP within the Plan, in accordance with its policies for other enrolled groups. However, for an enrollee of a single MCO under paragraph (b)(2) or (b)(3) of section 438.52, any limitation the Division imposes on his or her freedom to change between primary care providers may be no more restrictive than the limitation on disenrollment under 438.56(c). The Plan must agree to assign no more than two thousand (2,000) Members to any one full-time-equivalent provider in its network without the written approval of the Division. The Division encourages the Plan to include among its available providers any county, State, or Federally qualified provider that currently serves Recipients in the service area, including Federally Qualified Health Centers (FQHCs), in-plan school-based health services, and county health departments.

The Plan shall allow children with special needs who utilize Specialists frequently for their health care to maintain these types of Specialists as PCPs, or be allowed direct access to these Specialists for the needed care. A Member who has received prior authorization from the Plan for referral to a Specialist or for inpatient care shall be allowed to choose from among all the available Specialists and hospitals within the Plan, to the extent reasonable and appropriate.

The Plan shall implement procedures to ensure that each enrollee has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the enrollee. The Plan shall implement procedures to coordinate services it furnishes to the enrollee/member with services the enrollee/member receives from any other MCO, Prepaid Inpatient Health Plan (PIHP) or Prepaid Ambulatory Health Plan (PAHP). The Plan shall implement procedures to share with other MCOs, PIHPs or PAHPs serving the enrollee/member so that those activities need not be duplicated. The Plan shall implement procedures to share the results of its identification and assessment of the enrollee/member with special health care needs, as defined by the Division, so that these activities need not be duplicated.

Special needs children shall be identified by the Mecklenburg County DSS caseworker at the time of Medicaid eligibility determination. The Division shall identify the Children with Special Health Care Needs (CSHCN) on the monthly enrollment tape sent to the Plan.

The selected Plan must perform a needs assessment for all identified CSHCN by a qualified case manager utilizing a Division approved assessment tool within thirty (30) calendar days of enrollment, or in lieu of completing the assessment, make three (3) documented attempts to do the assessment within a maximum of forty five (45) days from the date of enrollment. If the special needs child is assessed as needing case management, a case manager shall be assigned within five (5) business days after determining the need for case management. The case managers must ensure the development of a comprehensive plan of care and treatment that assures coordination of services and continuity of care as required in 42 C.F.R. 438.208(c)(3).

The Plan must produce a treatment plan for enrollees with special health care needs that are determined through assessment to need a course of treatment or regular care monitoring, the treatment plan must be:

a. Developed by the enrollee's primary care provider with enrollee participation, and in consultation with any specialists caring for the enrollee;
b. Approved by the Plan, in a timely manner, if this approval is required by the Plan; and
c. In accord with any applicable Division quality assurance and utilization review standards.

The Plan must ensure that in the process of coordinating care, each enrollee's privacy is protected in accordance with the privacy requirements in 45 C.F.R. Parts 160 and 164 Subparts A and E, to the extent that they are applicable.

In the event that the recipient or responsible party does not select a Plan at the time of enrollment, the special needs child shall be auto-assigned by the HBM. The HBM shall review recent claims history to identify the current provider(s) and the special needs child shall be assigned to the Plan in which their current provider(s) participate(s) if available. If not available, the special needs child shall be assigned to the Plan and provider(s) that is capable of meeting the specific needs of the child.

The issue of enrollee privacy is addressed in Section 6.36 of the MCO contract that states: "Information about Medicaid Recipients, Medicaid applicants and provider eligibility, or the amount of assistance and services provided is confidential as defined by Federal and State law or by Division policy. The Plan must establish and implement policies and procedures consistent with confidentiality requirements of the HIPAA rule found in 45 C.F.R. Parts 160 and 164. Information must be made available for purposes directly connected with the administration of the program to include access to medical records for the purposes of quality management when requested in writing by the Division or its authorized designee."

4. Coverage and Authorization of Services

Sections 6.2, 6.3, 6.4 and Appendices I, III and IX of the MCO contract delineates the MCO's responsibilities for coverage and authorization of services for enrollees as follows: "The Plan shall provide to Recipients enrolled under this Contract, arrangements with others, all of the Covered Services identified in Appendix III and as set forth in this contract. Covered services must be medically necessary and provided by, or under the direction of a physician. The Plan shall provide the same standard of care for all Members regardless of eligibility category, and shall make all services as accessible in terms of timeliness, amount, duration and scope, to Medicaid Members, as those services are to non-enrolled Medicaid Recipients within the same area. Organ transplants shall be covered under the same conditions as fee-for-service. Covered services are defined in the respective Medicaid Provider Manuals and Bulletins, which are incorporated by reference. The Plan shall have in effect mechanisms to ensure consistent application of review criteria for authorization decisions; and consult with the requesting provider when appropriate.

In accordance with 1932(b)(2) of the Social Security Act as amended by the Balanced Budget Act (BBA) of 1997, the Plan shall provide coverage for emergency services consistent with the prudent layperson standard, as defined in Appendix I. Such services shall be provided at anytime without regard to prior authorization and without regard to the emergency care provider's contractual relationship with the Plan. The Plan shall also comply with guidelines relating to promoting efficient and timely coordination of appropriate maintenance and post-stabilization care provided to a Medicaid enrollee who is determined to be stable by a medical screening examination, as required under the Examination and Treatment for Emergency Medical Conditions and Women in Labor Act – EMTALA. (Section 1867 of the Social Security Act). (See Appendix XVI). The Plan is responsible for educating Members on the availability, location**,** and appropriate use of emergency services. The Plan may not deny payment for treatment obtained when an enrollee had an emergency medical condition, including but not limited to, cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 C.F.R. 438.114(a) of the definition of emergency medical condition.

The Plan must establish and maintain appropriate provider networks that are sufficient to provide adequate access to all services covered under the contract for the enrolled Medicaid population, including children with special health care needs. These provider networks shall offer an appropriate range of services and access to primary care, preventive services, and specialty services. This network of appropriate providers must be supported by written agreements. The network must have a sufficient number, mix, and geographic distribution of providers of services to assure

the Division that medically necessary Covered Services for the Plan's Members are delivered in a timely and appropriate manner according to the Division's Access Standards (Appendix XV). If particular specialty physician services are medically necessary but are not accessible within the Plan's network, the Plan must arrange for these services to be provided to its enrollees. The Plan must adequately and timely cover these services out of network for the enrollee for as long as the Plan is unable to provide them in network. The Plan shall ensure that all Covered In-Plan Services are as accessible to Members (in terms of timeliness, amount, duration, and scope) as those services are to non-enrolled Medicaid Recipients within the area and that no incentive is provided to providers, monetary or otherwise, for withholding medically necessary services.

Medically Necessary Services - Those services which are in the opinion of the treating physician, reasonable and necessary in establishing a diagnosis and providing palliative, curative or restorative treatment for physical and/or mental health conditions in accordance with the standards of medical practice generally accepted at the time the services are rendered. Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose; and the amount, duration, or scope of coverage may not arbitrarily be denied or reduced solely because of the diagnosis, type of illness, or condition (42 C.F.R. 440.230). Medicaid EPSDT coverage rules (42 U.S.C. 1396(r)(5) and 42 U.S.C. 1396d (a)).

In-Plan Benefits

- Adult Preventive Medicine Services
- Ambulance
- Chiropractic Services
- Clinic Services - Except for Mental Health and Substance Abuse
- Diagnostic Services
- Dialysis
- Durable Medical Equipment
- Emergency Room
- EPSDT/Health Check
- Eye Care
- Family Planning Services & Supplies
- Hearing Aids
- Home Health
- Home Infusion Therapy
- Hospice
- Inpatient Hospital - Except for Mental Health and Substance Abuse
- Laboratory Services
- Midwife
- Occupational Therapy

- Optical Supplies
- Outpatient Hospital
- Physical Therapy
- Physician Services, including Physician Assistants and Family Nurse Practitioners – Except for Mental Health and Substance Abuse
- Podiatry
- Postpartum Newborn Home Visit –EPSDT
- Postpartum Newborn Home Visit – Maternal Assessment
- Postpartum Newborn Home Visit – Newborn Assessment
- Private Duty Nursing
- Prosthetics/Orthotics
- Radiology Services
- Speech Therapy
- Sterilization
- Total Parenteral Nutrition

Out-of-Plan Benefits

- CAP Services
- At-Risk Case Management
- Child Service Coordination
- Dental
- D.S.S. Non Emergency Transportation
- Developmental Evaluation Center Services
- HIV Case Management
- ICF/MR
- Maternity Care Coordination
- Mental Health and Substance Abuse
- Mental Health - Inpatient & Outpatient
- Personal Care Services
- Prescription Drugs
- School-Related and Head Start Therapies
- Skilled or Intermediate Nursing Care

Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, must be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease."

B. Detailed information related to the access to care standards:

1. The state defines Children with Special Health Care Needs (CSHCN) as follows: "A "special health care needs" child, age birth through age 18, is defined as one who has one or more of the following conditions:

- Birth defect, including genetic, congenital or acquired disorders
- Developmental disability
- Mental or behavioral disorder
- Chronic and complex illness

These conditions are expected to continue at least 12 months, interfere with the child's daily routine and require extensive medical intervention and family management.

CMS has provided the following functional definition of CSHCN as stated in the January 19, 2001 State Medicaid Director letter, SMDL #01-012:

- Blind/Disabled Children and Related Populations (eligible for SSI under Title XVI)
- Eligible under section 1902(e)(3) of the Social Security Act (Not-applicable in NC - the eligibility category is not mandatorily enrolled)
- In foster care or other out-of-home placement
- Receiving foster care or adoption assistance
- Receiving services through a family-centered, community-based coordinated care system that receives grant funds under Section 501 (a)(1)(D) of Title V, as defined by the State in terms of either program participant or special health care needs.

In addition to the CMS categories listed above, the Division of Medical Assistance has instituted a questionnaire, with 5 2-part questions, for self-identification of children with Special Health Care Needs at the time of enrollment in Medicaid or Health Choice. This information is captured in the Eligibility Information System (EIS) to assist with reporting and monitoring of CSHCN.

The State has included a Special Needs indicator on the State eligibility data system that identifies the child by code to indicate the category as defined by the Balanced Budget Act of 1997 (BBA). Additionally, the State has included a questionnaire with the eligibility application for self identification in cases where the child may have special needs but is not included in the BBA defined categories listed above. The questionnaire is based on the results of questions that the State tested for the CAHPS survey by the University of North Carolina-Charlotte in collaboration with Harvard Medical School and the University of Massachusetts. These self-identified children are also coded into the State eligibility data system. The self-identified children may be those with diagnoses such as asthma or diabetes. The CSHCN code is then included on the monthly enrollment tapes sent to the MCO with the express purpose if early case management assessment by the MCO within 45 days of enrollment with the MCO. The State also identifies the numbers of CSHCN in the Medicaid-eligible

population by means of an annual report run through the DRIVE (Data Retrieval and Information Verification Engine) data system.

Case Management Assessment for Children With Special Health Care Needs requirements is addressed in Section 6.14 of the MCO contract as follows: **"**Special needs children shall be identified by the Mecklenburg County DSS caseworker at the time of Medicaid eligibility determination. The Division shall identify the Children with Special Health Care Needs (CSHCN) on the monthly enrollment tape sent to the Plan.

The selected Plan must perform a needs assessment for all identified CSHCN by a qualified case manager utilizing a Division approved assessment tool within thirty (30) calendar days of enrollment, or in lieu of completing the assessment, make three (3) documented attempts to do the assessment within a maximum of forty five (45) days from the date of enrollment. If the special needs child is assessed as needing case management, a case manager shall be assigned within five (5) business days after determining the need for case management. The case managers must ensure the development of a comprehensive plan of care and treatment that assures coordination of services and continuity of care as required in 42 C.F.R. 438.208(c)(3)."

2. The Plan must produce a treatment plan for enrollees with special health care needs that are determined through assessment to need a course of treatment or regular care monitoring, the treatment plan must be:

    a. Developed by the enrollee's primary care provider with enrollee participation, and in consultation with any specialists caring for the enrollee;
    b. Approved by the Plan, in a timely manner, if this approval is required by the Plan; and
    c. In accord with any applicable Division quality assurance and utilization review standards.

The Plan must ensure that in the process of coordinating care, each enrollee's privacy is protected in accordance with the privacy requirements in 45 C.F.R. Parts 160 and 164 Subparts A and E, to the extent that they are applicable.

In the event that the recipient or responsible party does not select a Plan at the time of enrollment, the special needs child shall be auto-assigned by the HBM. The HBM shall review recent claims history to identify the current provider(s) and the special needs child shall be assigned to the Plan in which their current provider(s) participate(s) if available. If not available, the special needs child shall be assigned to the Plan and provider(s) that is capable of meeting the specific needs of the child.

V. State standards for structure and operations

The MCO contract at 7.6 and 7.7 describes the requirements for provider selection and credentialing/recredentialing as: "The Plan shall have written policies and procedures for provider credentialing and recredentialing to identify providers who fall under its scope of authority and action and shall adhere to such polices and procedures. The Plan shall demonstrate that its providers are credentialed by providing the Division a copy of their policies and procedures. The Division shall review the Plan's provider credentialing and recredentialing process during the annual independent external review. The policies and procedures established by the Plan to verify and document provider credentials shall comply with all applicable State and Federal credentialing and recredentialing polices, requirements and regulations, including but not limited to, credentialing and recredentialing requirements as determined by the North Carolina Department of Insurance.

The Plan shall have written policies and procedures for the selection and retention of providers. The Plan shall not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. If the Plan declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision.

In all contracts with health care professionals, the Plan must comply with the requirements specified in 42 C.F.R. 438.214 which includes, selection and retention of providers, credentialing and recredentialing requirements and nondiscrimation. The Plan shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. The Plan shall not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128 A of the Social Security Act. The Plan shall consult the Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities (LEIE), the Medicare Exclusion Databases (MED) or the Excluded Parties Listing System (EPLS) to ensure that providers who are excluded from participation in Federal programs are not enrolled in the Plan network.

The Plan is not required to contract with providers beyond the number necessary to meet the needs of its enrollees.

The Plan is not precluded from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or

from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to enrollees."

Enrollee information is included in the MCO contract under requirements for the member services handbook and is found in section 6.11 which states the following: "The Plan shall provide each new Member, within fourteen (14) days from enrollment, written information on the Plan. All new Member Plan material must be approved by the Division prior to its release, and shall include at least the following information:

a. A list of PCPs, the procedures for selecting an individual physician and scheduling an initial health assessment encounter within the timeframes established in Sections 6.14 and 6.15 of this contract;
b. Procedures for changing PCPs or other practitioners;
c. Information specified in 42 C.F.R. 438.10(f)(6) and 42 C.F.R. 438.10(g);
d. Benefits and services provided and any limitations or exclusions applicable to In-Plan Services;
e. Procedures for notifying Members affected by the termination or change in any benefits, services, service delivery, or office site;
f. Member rights and responsibilities, including the right to voluntarily change or disenroll from a health plan, procedures for disenrollment and the right to change PCPs within the Plan;
g. Referral policy for specialty care and a current list of specialty care providers;
h. Provisions for after-hour and emergency care;
i. Role of primary care providers (PCPs);
j. How to access services;
k. The right to formulate Advance Directives;
l. Procedures for obtaining out of area coverage or services;
m. The right to receive family planning services and supplies from Out-of-Plan Providers;
n. Policies regarding the treatment of minors;
o. Any limitations that may apply to services obtained from Out-of-Plan Providers, including a disclosure of the responsibility of Members to pay for unauthorized health care services obtained from Out-of-Plan Providers, and the procedures for obtaining authorization for such services;
p. Circumstances under which a Member may transfer or be involuntarily disenrolled from the Plan;
q. Rights, procedures and timeframes for voicing or filing complaints and grievances or recommending changes in policies and services;

r. Rights, procedures and timeframes for appealing adverse determinations affecting coverage, benefits or enrollment, including the right to appeal directly to the Division;
s. Process for accessing the Health Benefits Manager;
t. Information about the Plan's ability to make reasonable accommodations for people with disabilities;
u. Information concerning transportation arrangements offered by the Plan;
v. Charges to Members.

Confidentiality of medical information is addressed in the MCO contract under section 8.2. that requires the following: "The Plan shall comply with the requirements of 42 C.F.R 431 Subpart F and 45 C.F.R. Parts 160 and 164, to restrict the use or disclosure of information concerning Members to purposes directly related to the performance of its duties and securement of its rights under this Contract. The Division, the State Attorney General's Office, the State Audit Department, authorized Federal or State personnel, or the authorized representatives of these parties including, without limitation, any employee, agent, or contractor of the Division, CMS, and the Department of Health and Human Services, shall have access to all confidential information in accordance with the requirements of this Contract and State and Federal law and regulations pertaining to such access."

Enrollment and Disenrollment is addressed in the MCO contract under Sections 4.1, 4.4, 4.5, 4.6, 4.7, 4.8 and 4.9. These sections state: "Recipients shall select and be assigned to a Plan through the Mecklenburg County Department of Social Services (DSS) or an independent Health Benefits Manager (HBM) who shall perform this function under separate contract to the Division. The Plan is prohibited from enrolling Recipients directly or conducting any point of sale marketing. The Plan shall provide for a continuous open enrollment throughout the term of this Contract and shall enroll all eligible Recipients without restriction, in the order in which they apply through the county DSS or HBM; and shall further agree to enroll up to a minimum of 5,000 Recipients, subject to the limitations set forth in Sections 4.2 and 6.8.

The Plan shall not discriminate against individuals eligible to enroll on the basis of race, color, or national origin and shall not use any policy or practice that has the effect of discriminating on the basis of race, color or national origin. Furthermore, the Plan shall not discriminate on the basis of health status or the need for health care services against individuals eligible to enroll.

Eligible family members in the same case must select the same Plan. Family members shall be permitted to choose different providers within the

same Plan. Eligible Members residing in the same household are encouraged to select the same Plan, but are not required to do so. Eligible Recipients who do not voluntarily select a Plan within ten (10) business days of the date of interview with the county DSS or HBM, (thirty days (30) for MAD and MAB Recipients), shall be assigned to a Plan according to an algorithm approved by the Division.

An enrollment period shall always begin on the first day of a calendar month and shall end on the last day of a calendar month, with the exception of newborns. Disenrollments and plan transfers shall be effective no earlier than the first of the month following the request or reason for disenrollment or transfer, and no later than the first of the second month following a request or reason for disenrollment or transfer.

When a retroactive disability determination is made for a Recipient who is enrolled in a Plan, the change in payment category shall occur at the time of the change in the Recipient's aid program category within the Division's Eligibility Information System (EIS). Changes in recipient aid program categories are not generally retroactive for the Blind and Disabled.

A Recipient whose membership in the Plan is terminated due to ineligibility as defined in Section 3 – MEMBER ELIGIBILITY shall be automatically re-enrolled in the Plan if eligibility is resumed within two months, unless the recipient selects a new Plan.

A Recipient shall be automatically disenrolled from the Plan if the Recipient:

a. no longer resides in the Service Area;
b. is deceased;
c. is admitted to a long-term care facility or a correctional facility for more than thirty (30) days;
d. no longer qualifies for Medicaid or becomes a Recipient ineligible for enrollment as defined in Section 3.2.

The Plan may request involuntary disenrollment of a Member only for Good Cause, and must submit such request in writing, including remedial steps taken and documentation of good cause, to the Division. Good Cause is defined as:

a. Behavior on the part of a Member, which is disruptive, unruly, abusive, or uncooperative to the extent that the ability of the Plan to provide services to the Member or other affected Members, is seriously impaired;
b. Persistent refusal of a Member to follow a reasonable, prescribed course of treatment or;
c. Fraudulent use of the Medicaid card or the Member ID card issued by

the Plan.

If the Plan requests the disenrollment of a Member, the reasons for disenrollment may not be discriminatory in any way against the Member, i.e., adverse change in a Member's health status; non-compliant behavior for individuals with mental health and substance abuse diagnoses; pre-existing medical conditions; high cost medical needs; need for health care services or the exercise by a Member of their right to file a complaint, grievance or appeal. Requests for involuntary disenrollments must be submitted in writing to the Division. The Division shall render a decision within ten (10) business days of receipt of request and adequate supporting documentation. Involuntary disenrollments, which are granted by the Division, are subject to the data processing deadlines as set forth in Section 4.4 – Effective Date of Enrollment/Disenrollment.

The Plan shall submit to the Division its policies and procedures for assuring that each disenrollment request is consistent with Good Cause, as defined in this Section. The written policies and procedures must include a description of the remedial steps the Plan shall take to obtain Member compliance, preceding all requests for involuntary disenrollment.

Members may voluntarily disenroll from the Plan, and transfer to another available health care option at any time without cause. The recipient (or his or her representative) must submit an oral or written request for disenrollment to the Division or the Division's designee. The transfer shall be effective the first day of the next calendar month, subject to data processing deadlines, but in no case shall it be effective later than the first day of the second month after the transfer is requested."

The required grievance system is included in the MCO contract at section 7.5 and Appendix IX (see attached). Section 7.5 states, "The Plan shall have a timely and organized system with written policies and procedures for resolving internal grievances in accordance with 42 C.F.R. 438.228, 42 C.F.R. 438 Subpart F, and the requirements set forth in Appendix IX, that:

a. Is approved in writing by the Division;
b. Provides for prompt resolution; and
c. Assures the participation of individuals with the authority to require corrective action.

Tracking and analysis of transfers, complaints, and grievance data shall be used by the Plan for quality improvement. All Medicaid Member grievances, complaints, and appeals must be reported by number and type and with action taken for resolution. Reports must be submitted no later then forty five (45) calendar days after the end of a calendar quarter. The

Plan must comply with requirements for grievance procedures and reporting in Appendix V Statistical Reporting and Appendix IX Grievance Procedures."

Subcontractual relationship and delegation requirements are found in section 12.1 of the MCO, "The Plan may enter into subcontracts for the performance of its administrative functions or for the provision of various Covered Services to Members. The Plan must evaluate a prospective subcontractor's ability to perform the activities to be delegated. The Plan shall monitor the subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule consistent with industry standards. The Plan shall identify deficiencies or areas for improvement in the subcontractor's performance and require the subcontractor to take corrective action.

Each subcontract, and any amendment to a subcontract, shall be in writing and approved in writing by the Division. All subcontracts must fulfill the requirements of 42 C.F.R. 438.6 and 42 C.F.R. 434.6 that are appropriate to the service or activity delegated under the subcontract. The subcontract must specify the activities and report responsibilities delegated to the subcontractor and provide for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.

All subcontractors must be eligible for participation in the Medicaid program and are bound to all the terms of this Contract and applicable Federal and State laws and regulations. No subcontract shall in any way relieve the Plan of any responsibility for the performance of its duties pursuant to this Contract. The Plan shall notify the Division in writing of the termination of any approved subcontract within ten (10) days following termination. All subcontracts must clearly identify the functions that are subcontracted and provide the Division upon request with results from any audits or reviews of subcontractors. All subcontracts shall:

a. Identify the population covered by the subcontract;
b. Specify the amount, duration and scope of services to be provided by the subcontractor;
c. Specify procedures and criteria for extension, re-negotiation and termination;
d. Make full disclosure of the method and amount of compensation or other consideration to be received from the Plan;
e. Provide for monitoring by the Plan of the quality of services rendered to Members;
f. All subcontracts shall contain a provision that the Plan monitor the subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule consistent with industry standards;
g. All subcontracts shall contain a provision that upon the Plan's

identification of deficiencies or areas for improvement in the subcontractor's performance, the subcontractor must take corrective action;

h. Contain no provision which provides incentives, monetary or otherwise, for the withholding from Members of medically necessary services;
i. Contain a prohibition on assignment or any further subcontracting without the prior written consent of the Division; and
j. Incorporate all provisions of this Contract to the fullest extent applicable to the service or activity delegated pursuant to the subcontract, including State laws and regulations, all rules, policies and procedures of the Department and Division, and all standards governing the provision of Covered Services and information to Members; all quality assurance requirements; all record keeping and reporting requirements; the obligation to maintain the confidentiality of information; all rights of the Division and other officials to inspect, monitor and audit operations; the rights of the Division and other State/Federal officials to inspect and audit any financial records; all indemnification and insurance."

B. Detailed information related to the structure and operation standards including state procedures for the review of the records of MCO grievances and appeals and for identifying and resolving systemic problems:

This information is included in section 7.5 and Appendix IX (see attached) of the MCO contract, 7.5 states, " The Plan shall have a timely and organized system with written policies and procedures for resolving internal grievances in accordance with 42 C.F.R. 438.228, 42 C.F.R. 438 Subpart F, and the requirements set forth in Appendix IX, that:

a. Is approved in writing by the Division;
b. Provides for prompt resolution; and
c. Assures the participation of individuals with the authority to require corrective action.

Tracking and analysis of transfers, complaints, and grievance data shall be used by the Plan for quality improvement. All Medicaid Member grievances, complaints, and appeals must be reported by number and type and with action taken for resolution. Reports must be submitted no later then forty five (45) calendar days after the end of a calendar quarter. The Plan must comply with requirements for grievance procedures and reporting in Appendix V Statistical Reporting and Appendix IX Grievance Procedures."

VI. State Standards for quality measurement and improvement

1. Practice guideline requirements are covered in section 7.1 of the MCO contract:
   - Develop and/or adopt clinically appropriate practice parameters and protocols/guidelines and provide the Plan's providers enough

information about the protocols/guidelines to enable them to meet the established standards;

- Evaluate access to care for Enrollees according to established standards and those developed by the Plan and implement a process for ensuring that network providers meet and maintain the standards. The evaluation should include an analysis of the accessibility of services to Enrollees with disabilities.

2. The quality assessment and performance improvement program is included in section 7.1 and Appendix XVII (see attached) of the MCO contract. Section 7.1 states, "The Plan shall establish and maintain a written program for Quality Assurance/Performance Improvement ("QA/PI") consistent with 42 C.F.R. 434.34 and 42 C.F.R. 438.240 and with the utilization control program required by CMS for the Division's overall Medicaid program as described in 42 C.F.R. 456.

   The Plan shall submit the written Quality Assurance/Performance Improvement program description and a summary of progress toward performance improvement goals to the Division on an annual basis no later than June 30th of each calendar year.

   The written program must describe, at a minimum, how the Plan shall:
   - Achieve CMS and/or Division or Plan defined minimum performance levels on standardized quality measures annually. (See Appendix XVIII for Benchmark Performance Levels);
   - Develop and implement performance improvement projects using data from multiple sources that focus on clinical and non-clinical areas. These projects must achieve, through ongoing measurements and intervention, demonstrable and sustained improvement in significant aspects of care that can be expected to have a favorable effect on health outcomes and enrollee satisfaction;
   - Have in effect mechanisms to detect both over and under utilization of services;
   - Have in effect mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs;
   - Have a comprehensive scope that assures all demographic groups, care settings, and types of services are included in the scope of the review occurring over multiple review periods;
   - Measure the performance of Plan providers and conduct peer review activities such as: identification of practices that do not meet Plan standards; recommendation of appropriate action to correct deficiencies; and monitoring of corrective action by providers;
   - Measure provider performance through inclusion of medical record audits;
   - Provide performance feedback to providers, including detailed discussion of clinical standards and expectations of the Plan;

- Develop and/or adopt clinically appropriate practice parameters and protocols/guidelines and provide the Plan's providers enough information about the protocols/guidelines to enable them to meet the established standards;
- Evaluate access to care for Enrollees according to established standards and those developed by the Plan and implement a process for ensuring that network providers meet and maintain the standards. The evaluation should include an analysis of the accessibility of services to Enrollees with disabilities.

1. The Plan shall develop, implement, and report to the Division a minimum of two (2) plan-specific and self-funded performance improvement projects the first year of this contract: one focusing on a clinical area and one focusing on a non-clinical area. The topics for these projects shall be jointly determined by the Plan and the Division based on statistical reports submitted to the Division the previous year**.** Progress summaries of these projects shall be submitted to the Division by June 30 of each calendar year. (See Appendix V and XVI). For year two of this contract, the Plan shall conduct a performance improvement project in addition to the two planned for the first year of this contract for a total of three. For year three of the contract, the Plan shall conduct an additional performance improvement project for a total of four. The project topics shall be jointly determined by the Plan and the Division unless mandated by CMS and based on Plan performance as measured by annual reporting to the Division;
2. The plan, at its own expense, shall participate annually in at least one (1) statewide performance improvement project. (See Appendix V);
3. The Plan shall conduct an annual Consumer Assessment of Health Plans Survey (CAHPS), utilizing the sampling and format as defined by NCQA. The results of the survey must be filed with the Division as stated in Appendix V, Statistical Reporting Requirements;
4. The Plan shall maintain an active QA/PI committee or other structure, which shall be responsible for carrying out the planned activities of the Quality Assessment/Performance Improvement program. This committee shall have regular meetings, shall document attendance by providers, and shall be accountable and report regularly to the governing board or its designee concerning QA/PI activities. The Plan shall maintain records documenting the committee's findings, recommendations, and actions;

5. The Plan shall designate a senior executive who shall be responsible for program implementation. The Plan's Medical Director shall have substantial involvement in the QA/PI program functions, such as credentialing and utilization review and review and monitoring of its subcontractors.

2. Health Information systems requirements are found in section 7.8 of the MCO contract and states, "The Plan must maintain a health information system that collects, analyzes, integrates, and reports data. The system must provide information on areas including, but not limited to, utilization, grievances and appeals, and disenrollments for other than loss of Medicaid eligibility. The Plan must collect data on enrollee and provider characteristics as specified by the Division, and on services furnished to enrollees through an encounter data system or other methods as may be specified by the Division. The Plan must make all collected data available to the Division and upon request to CMS.

   The Plan must ensure that data received from providers is accurate and complete by:
   a. Verifying the accuracy and timeliness of reported data;
   b. Screening the data for completeness, logic, and consistency; and
   c. Collecting service information in standardized formats to the extent feasible and appropriate."

B. Detailed information related to the quality measurement and improvement standards

1. A description of the methods and timeframes to assess the quality and appropriateness of care and services is found in Appendix V of the MCO contract (see attached).

2. The identification of children with special health care needs is accomplished at the time of recipient application at the county DSS. The state uses the CMS functional definition of CSHCN as stated in the January 19, 2001 State Medicaid Director letter, SMDL #01-012:

- Blind/Disabled Children and Related Populations (eligible for SSI under Title XVI)
- Eligible under section 1902(e)(3) of the Social Security Act (Not-applicable in NC - the eligibility category is not mandatorily enrolled)*
- In foster care or other out-of-home placement
- Receiving foster care or adoption assistance
- Receiving services through a family-centered, community-based coordinated care system that receives grant funds under Section 501

(a)(1)(D) of Title V, as defined by the State in terms of either program participant or special health care needs.

* *Note: The State does not enroll this population in Managed Care Programs*

In addition to the categories listed above, the Division of Medical Assistance has instituted a questionnaire, with 5 2-part questions, for self-identification of children with Special Health Care Needs at the time of enrollment in Medicaid or Health Choice. This information is captured in the Eligibility Information System to assist with reporting and monitoring of CSHCN.

3. CSHCNs will be assessed as outlined in section 6.14 of the MCO contract, which states, "Special needs children shall be identified by the Mecklenburg County DSS caseworker at the time of Medicaid eligibility determination. The Division shall identify the Children with Special Health Care Needs (CSHCN) on the monthly enrollment tape sent to the Plan. The selected Plan must perform a needs assessment for all identified CSHCN by a qualified case manager utilizing a Division approved assessment tool within thirty (30) calendar days of enrollment, or in lieu of completing the assessment, make three (3) documented attempts to do the assessment within a maximum of forty five (45) days from the date of enrollment. If the special needs child is assessed as needing case management, a case manager shall be assigned within five (5) business days after determining the need for case management. The case managers must ensure the development of a comprehensive plan of care and treatment that assures coordination of services and continuity of care as required in 42 C.F.R. 438.208(c)(3). The Plan must produce a treatment plan for enrollees with special health care needs that are determined through assessment to need a course of treatment or regular care monitoring, the treatment plan must be:

a. Developed by the enrollee's primary care provider with enrollee participation, and in consultation with any specialists caring for the enrollee;
b. Approved by the Plan, in a timely manner, if this approval is required by the Plan; and
c. In accord with any applicable Division quality assurance and utilization review standards.

The Plan must ensure that in the process of coordinating care, each enrollee's privacy is protected in accordance with the privacy requirements in 45 C.F.R. Parts 160 and 164 Subparts A and E, to the extent that they are applicable.

In the event that the recipient or responsible party does not select a Plan at the time of enrollment, the special needs child shall be auto-assigned by the HBM. The HBM shall review recent claims history to identify the current

provider(s) and the special needs child shall be assigned to the Plan in which their current provider(s) participate(s) if available. If not available, the special needs child shall be assigned to the Plan and provider(s) that is capable of meeting the specific needs of the child."

4. In Appendix V (see attached), the State requires the MCO to report regularly measures to assess the quality and appropriateness of care and services furnished under the MCO contract to all recipients, including CSHCNs. For measures relating to children, the State has required a subset report for CSHCNs as indicated.

5. The State will utilize DRIVE (Data Retrieval and Information Verification Engine), a data warehouse with a subset of MMIS+ data, to support the ongoing assessment of the quality strategy. Currently, DMA Information Systems staff runs annual HEDIS data from DRIVE that compares selected measures across all systems of managed care in North Carolina. The encounter data included in the DRIVE will be available to produce reporting on performance indicators and any additional measures needed.

VI. State Monitoring and Evaluation

The State will review the submitted reporting as required in Appendix V (see attached) and will provide feedback to the Plan regarding performance on benchmark measures. The State will compare the State-generated HEDIS measures with the Plan-generated measures. Following review of the HEDIS and DMA specified reporting, during the 3rd and 4th quarters, the State will assist the Plan in identifying clinical and non-clinical performance improvement projects for implementation during the following calendar year. In addition the State will conduct an onsite visit with the Plan to evaluate contractual requirements and will contract with an EQRO for an annual external quality review as required by the BBA.

A. Arrangements for external quality reviews

In order to comply with BBA requirements, the State plans to amend the current contract with Medical Review of North Carolina, Inc contract to include the external quality review (EQR) requirements as outlined in the BBA. This contract will end during the fourth quarter of 2004 at which time we will issue a request for proposal for EQRO contracting effective January 1, 2005. Each year the EQR will consist of the validation of Plan-generated HEDIS/DMA measures and an evaluation of the Plan's performance improvement projects and focused care studies. This evaluation will occur during the 2nd and 3rd quarter of each year with a final report due to DMA during the 4th quarter of each year. The report information will be used to evaluate the effectiveness of the State's quality

strategy and the strategy will be amended as needed for the following calendar year.

B. Not applicable

VII. Procedures for race, ethnicity and primary language

A. The State plans to identify the race, ethnicity and primary language of each Medicaid MCO enrollee at the time of application at the DSS. The caseworker will enter the data into the Eligibility Information System (EIS) as instructed by the State. This information will be downloaded into the MMIS+ and DRIVE and will be placed on the monthly MCO enrollment report.

B. The SSI population is a difficult and costly one for the State to reach effectively. Even race is often not reported by SSA to us on SSI recipients. Our plan is to code race into our EIS as unreported when SSA sends us "unknown" as the race indication.

Any attempt to collect this information will require funds and staffing resources that the State does not have available at this time. The State will explore options to address this issue.

The State's race, ethnicity and primary language categories are:

Race:
1. American Indian or Alaska Native
2. Asian
3. Black or African American
4. Native Hawaiian or other Pacific Islander
5. White
6. Unreported

Ethnicity:
1. Hispanic or Latino
2. Not Hispanic or Latino

Primary Language:
1. English
2 Hmong
3. Russian
4. Spanish
5. Other.

VIII. National Performance Measures and Level

To be determined

IX. Intermediate Sanctions

The State describes the use of intermediate sanctions in support of its quality strategy in section 14.5 of the MCO contract, which states, **"**The types of intermediate sanctions that the Division may impose include the following:

- Civil money penalties in the amounts specified in 42 C.F.R. 438.704;
- Appointment of temporary management as provided in 42 C.F.R. 438.706;
- Granting enrollees the right to terminate enrollment without cause and notifying the affected enrollees of their right to disenroll;
- Suspension of all new enrollment, including default enrollment, after the effective date of the sanction;
- Suspension of payment for Recipients enrolled after the effective date of the sanction and until CMS or the Division is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

The Division shall retain authority to impose additional sanctions under State statutes or State regulations that address areas of noncompliance specified in 42 C.F.R. 438.700, as well as additional areas of noncompliance.

The limit on, or the maximum civil money penalty the Division may impose varies depending on the nature of the Plan's action or failure to act.

The limit is $25,000 for each of the following determinations:

a. Failure to provide services;
b. Misrepresentation or false statements to enrollees, potential enrollees, or health care providers;
c. Failure to comply with physician incentive plan requirements;
d. Marketing violations.

The limit is $100,000 for each determination of:

a. Acts of discrimination among enrollees on the basis of their health status or need for health care services;
b. Misrepresentation or false statements to CMS or the Division.

The limit is $15,000 for each recipient the Division determines was not enrolled because of a discriminatory practice as stated in 42 C.F.R. 438.700(b)(3). This is subject to the overall limit of $100,000 stated above.

For premiums or charges in excess of the amounts permitted under the Medicaid program, the maximum amount of the penalty is $25,000 or double the amount of the excess charges, whichever is greater. The Division must deduct from the penalty the amount of overcharge and return it to the affected enrollees."